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ABSTRACT

Research indicates children in group care have increased risk of infectious illnesses compared to those cared for at home. The health practices of child care center staff, children, and parents will influence the incidence of illness. The issues discussed in the book relate to some of the indicators of selected health accreditation principles in the National Childcare Accreditation Council's handbook. This book is part of a series designed to provide practical support to services participating in the Quality Improvement and Accreditation System. Specific principles are listed at the beginning of each chapter. The aim of the book is to provide child care workers with ideas for best health practices and to give some supporting information to justify each practice. The first topic area addressed in the book is the "health and welfare of children" including healthy children, child welfare, and the sick child. The second topic area is "clothing and sun protection." The third topic area, "infection prevention and control," includes hand washing, cleaning and disinfection, diapering and toileting, and food practices. The fourth area focuses on "dental care." fifth topic area is "immunization," including information on updating of medical records, reactions to immunizations, and reporting infectious diseases. Contains 21 references. (SD)

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Accreditation & Beyond

Highlighting health

A discussion of health practices and accreditation

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Highlighting health

Claire Bell

Foreword

Thinking about what is done and why, about whether it can be done better and how, is a process which is at the heart of improved practice in child care no less than in any other field.

The Accreditation and Beyond Series supports that process in practical ways.

Each of the books in the series puts ideas about good practice up against the understandings about children and their needs on which they are based. This is done deliberately. There are no recipes for good practice. There are, however, principles that can be used as a benchmark for deciding whether what is being done is good for children and the people who work with them. Many of these are drawn out in this series.

The impetus for the series was to provide practical support to services participating in the Quality Improvement and Accreditation System. However, it is also intended that the series be an ongoing reference for early childhood professionals and services working to provide quality care for children.

It is not meant to be a final statement on any of the areas it covers and the range and depth of the series is deliberately diverse as is the child care sector.

Highlighting health takes up the concern that children in group care have increased risks of illnesses compared to those cared for at home. Using selected health principles from the Quality Improvement and Accreditation System handbook it will assist services to put in place practices and policies. This will mean that the incidence of illness in the service is minimised.

Other titles in the series are:

- Staff–Child interactions: A Vygotskian perspective;
- Babies need more than minding: Planning programs for babies and toddlers in group settings;
- The very best of care and education: Many ways to the Quality Improvement & Accreditation System;
- The policy handbook: Developing policies in child care;
- Surviving Accreditation: A QIAS ideas bank; and
- Thought for food: A starting point for children's nutritional meals.

AECA hopes that these books will assist in making the accreditation experience rich, constructive and successful, and that the series will be an ongoing resource to services.

Tonia Godhard
President

For their contributions

Hilary Lang and Debbie Nicol.

Drawings courtesy of Alice Callahan.
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Introduction

Research indicates children in group care have increased risks of infectious illnesses compared to those cared for at home. They have more episodes of upper respiratory tract infections, middle-ear infections, pneumonia, and gastroenteritis (Ferson, 1994).

The health practices of child care centre staff, the children, and the parents will influence the incidence of illness.

Issues discussed in this book relate to some of the indicators of selected health accreditation principles in the National Childcare Accreditation Council publication *Putting children first: Quality Improvement and Accreditation System handbook*, 1993. The principles are listed in this introduction and at the beginning of each chapter. The aim of the book is to provide child care workers with ideas for best health practices and to give some supporting information to justify the practice.

Information relating to nutrition has not been included in this book (principles 36, 37 and 38). The AECA publication *Thought for food* (1995) covers these principles.

The principles discussed in this book are:

- Principle 34: Staff are alert to the health and welfare of each child.
- Principle 35: Staff try to ensure that children are clothed appropriately for indoor and outdoor play and for sleep.
- Principle 39: Staff adhere to hygiene principles which reduce the spread of infectious diseases.
- Principle 40: Staffing encourage children to follow simple rules of hygiene.
- Principle 43: The centre maintains a record of children's immunisations.
- Principle 44: The centre has written policies on hygiene, medical, emergency and accident procedures.

'Possible Policy and Procedure Issues' have been included at the end of each section. Readers may wish to consider these points in combination with the books *The policy handbook, Staying healthy in child care* and *Health and safety in child care centres: Model policy and practice.* These three books are available from the Australian Early Childhood Association Inc. (AECA).

One thing that needs to be stressed is that you are either clean or not, there are no grades; you can't be a little clean, if you are you are a little dirty! The same with safety, you are either safe or are unsafe. Infection control and safety procedures have to be in place the whole time, this is why the QIAS ratings are basic.

The health and welfare of children

Principle 3.4: Staff are alert to the health and welfare of each child.

Healthy Children

Health checks

Each day a staff member needs to be available to welcome the children and parents as they arrive. This provides the parent with the opportunity to discuss any concerns, and for staff to quickly assess the child and ascertain if he or she is well and able to cope with the day's activities. This is best done by staff who have had ongoing contact with the child. Communication with the parents needs to be such that an open and trusting relationship can develop, allowing parents to feel comfortable to share information about illness and well being within the family.

Children are generally energetic and keen to explore their environment. Child care workers become familiar with each child they care for and know their behaviour patterns. Changes in their usual behaviour can be a sign of illness.

Children can become ill quickly. Staff need to always watch for, and be quick to pick up on, any signs or symptoms of illness. At the same time, parents need to be well informed of the centre's policy and helped, if necessary, by the staff to identify when a child is not well enough to attend the centre.

Indicators of illness

Specific indicators of ill health may include the following signs and symptoms which can alert the child care staff to assess the child more thoroughly:

- vomiting
- floppiness
- fever
- diarrhoea, blood in faeces, pale faeces
- runny nose and/or eyes, eye inflammation
- excessive drooling, sore throat, or difficulty swallowing
- persistent screaming
- inability to be consoled
- complaints of aches, pain, discomfort
- rash, itching, and skin irritation
- restricted movement (e.g. limping)
- pallor/flushed face
- loss of appetite
- altered state of consciousness
- stiffness, especially of the neck
- breathing difficulties

The last three indicators require prompt action.

Possible policy and procedure issues

Some issues your centre may wish to consider are:

- who is responsible for checking children on arrival?;
- the availability of information to staff about children with conditions which could require urgent treatment;
- the availability of information to parents about childhood illnesses; and
- who has the authority to refuse to accept a child who is unwell?

Child welfare

Child abuse and neglect

Child care workers are required as part of their professional duty to report any suspected cases of abuse and/or neglect. This abuse or neglect can be happening inside or outside the centre. The director is responsible for reporting all suspected cases to the appropriate authorities. However, if a staff member feels abuse is occurring in the centre they may approach the authorities directly.

Specific behaviour and developmental problems may be indicators of abuse and neglect. The regular summarising of written developmental observations can be one source of reliable reference for concerns relating to this area. Observations need to be kept confidential.

A written centre policy on behaviour management and supervision could also help to reduce the risk of any abuse within the centre as well as regular staff development sessions on topics such as stress management and child abuse and neglect.

Different cultural practices

Each child care worker needs to ensure she/he is familiar with the different cultural practices in care giving, behaviour management, and hygiene for the children in their care. For example, it is an Assyrian belief that children will become very ill if exposed to a strong wind. This may mean that Assyrian parents are very reluctant to have their children go outside or on excursions on windy days. Another is the belief that a sick child should be kept tightly wrapped and warm — control of febrile convulsions may mean this is not appropriate.

A suitable time to collect the relevant information from the parent(s) would be when a child is first enrolled at the centre. The information would then need to be updated regularly. It should not be assumed that all children of a particular culture are cared for in the same way, just as they are not all cared for in the same way in the Australian culture. Similarly, the parents need to be informed of the values and practices of the centre and any differences discussed, e.g. gender equity, anti-bias, and behaviour management.

Possible policy and procedure issues

Some issues your centre may wish to consider could be:

- orientation for new staff re policy and regulations on child abuse and neglect;
- continuing professional development for trained and untrained staff;
- staff behaviour management practices;
- expected record keeping;
- legal requirements; and
- how confidentiality will be maintained.

The child who is unwell

Principle 44: The centre has written policies on hygiene, medical, emergency and accident procedures.

Prompt and correct care of a child who is unwell will help to reduce the spread of infection throughout the centre.

Parent notification

A written policy concerning the management of the child who is unwell, along with exclusion guidelines, should be given to, and discussed with, the parent(s) at the time of enrolment. Parents need to be aware that they could be contacted to take their child home if he or she becomes ill while in care. Parent contact numbers need to be kept up to date for this purpose. Parents appreciate being informed via telephone when their child is unwell, even if at that stage exclusion has not been determined as necessary.

Ensuring that parents have a copy of the written policy can help to avoid problems at a later date if parents are experiencing difficulty in collecting their child early.

Separation and exclusion

A child who is observed to be unwell should be assessed by the staff to determine if separation from the group and exclusion from the centre is necessary. In the case of the child having an infectious disease, the National Health and Medical Research Council's (NHMRC) recommended minimum periods for exclusion should be followed (refer to Department of Human Services and Health, 1994, p.35–36). These children need to be separated from the group to prevent spread of the infection. Once taken home, they need to remain away from the centre until they have met the exclusion guidelines and are well enough to return and cope with the usual daily activities.

In the event of the diagnosis of a case of a vaccine preventable disease within the centre, any unimmunised child and/or staff should be excluded for the recommended time in consultation with the relevant Public Health Authorities.

Children who are mildly ill with, for example, a cold or with chronic infection, such as hepatitis B, are not usually excluded, as correct hygiene practices prevent infection of other children and staff.

Short-term care

The child requiring separation before going home should be made comfortable and, if indicated, have his or her

temperature taken. Steps can then be taken to reduce the temperature if necessary. This can be done in the following ways:

- Remove excess clothing.
- Ensure the area is well ventilated. If a fan is used for this purpose, it should not go directly onto the child as it can cool it too quickly. A hot, irritable child will usually object to the fan blowing onto it.
- Encourage the child to lie or sit without being held. The child will cool quicker without the body heat of another person.
- Encourage frequent small amounts of clear fluids — if the child's condition permits.
- A lukewarm face cloth on the forehead and, if tolerated, on the neck and in the armpits, may be applied at frequent intervals. Cold water should not be used, as it will usually make the child cry. Crying will make the child hot and frustrated at a time when it is best for the child to be calm. Cold water can also cool the child too quickly, causing shivering, a mechanism for warming the body.
- Paracetamol may be given if indicated. Parental consent is required before administration.

Ideally, and if staffing permits, a child care worker familiar to the child should stay and look after the child, and not care for other children until after the child has gone home. Comfort and reassurance are an important aspect of the care required.

Prevention of the spread of the infection is also an important aspect of care. Children who are unwell should still be reminded and encouraged to wash their hands after using a tissue, coughing, sneezing and going to the toilet. Carers should also be particular about hand-washing and should do this before returning to care for other children.

After a child with an infectious disease has been taken home from the centre, the

rest and bathroom area used by the child, plus toys, need to be cleaned and disinfected. Refer to the Department of Human Services and Health publication *Staying Healthy in Child Care: Preventing infectious diseases in child care*, chapter 5, 1993, for further information on cleaning.

Informing parents and all centre staff of infectious diseases as they occur at the centre will enable them to watch for early signs and symptoms. Staff also need to recognise when they themselves are unwell, and stay away from the centre when ill. Early exclusion of both children and staff should reduce the spread of the infection.

Administration of medication to children

On occasions, a child/children will require the administration of medication while at the centre. Children with chronic conditions (e.g. asthma, cystic fibrosis) may be on medication for extended periods.

The State and Territory regulations for the administration of medication vary. However, important aspects of medication storage and administration that need to be remembered include:

- Medication should be stored in its original container at the temperature stated on the bottle/packet. For safety reasons, medication should be stored in child-resistant safety containers both in and out of the refrigerator. Refrigerator doors may not always be at a cool enough temperature for particular medications. Storing them on an inside shelf is more desirable. Medication requiring refrigeration should remain in the refrigerator until immediately before the child goes home.
- Written parent/guardian consent is necessary prior to giving medication. This also includes non-prescription medication. At enrolment the director can ask parents to sign consent for the administration of paracetamol in the case of a high temperature. Teething ointments and sunscreen are also examples of non-prescription medications for which consent may be obtained at the time of enrolment. When written consent has not been obtained, verbal consent via the telephone should be obtained prior to administration. Written consent should later be obtained from the parent (Harris, M., Harris, E., Ferson, M., Sherry, K., Frith, F., Burraston, B. & Barratt, A., 1994).
- Check the expiry date before giving any medication.
- Give medication only to the child for whom it is prescribed.
- Measure medication correctly.
- Record administration correctly in the medication register.
- Warn parents if, for any reason, medication is not given.

The child's allergies, if any, need to be noted. Staff should be aware of and watch for, drug side-effects.

Reporting of notifiable diseases

A medical record, or illness register, should be maintained by the centre. The name of the child, date, and the infectious or notifiable disease should be entered if or when confirmed. The appropriate health authorities should be informed by the centre director (Harris, M. *et al.*, 1994).

First aid qualifications

- A member of staff with a current first aid certificate should be on duty at all times.
- First aid qualifications require updating every three years. St John Ambulance and Red Cross offer a refresher course every 12 months, after which the three-year certificate is extended another 12 months.

The first aid kit needs to be kept up to date and adequately stocked. In some areas, St John Ambulance will check and re-stock first aid kits free of charge except for cost of replacement items.

Possible policy and procedure issues

Some issues your centre may wish to consider are:

- procedure to follow when a child is not well;
- procedure for the administration of medication, both prescription and non-prescription;
- procedure for when parent consent can not be obtained;
- who gives medication?;
- specific situations when parent(s) will be telephoned to advise their child is unwell;
- exclusion guidelines for children and staff;
- when is urgent medical attention necessary?;
- when is an ambulance called?;
- who decides when an ambulance is called?;
- copy of policies for parents; and
- updating of parent/emergency contact telephone numbers.

Care needs to be taken to ensure that the policy is updated regularly.

Clothing and sun protection

Principle 35:
Staff try to ensure that children are clothed appropriately for indoor and outdoor play and for sleep.

Clothing

Changes in clothing requirements

A child's clothing requirements change during the day. Changes in activity levels, such as when the children moves from play to sleep and indoor to outdoor play, can be a time to check clothing requirements.

Daily clothing required

Parents need to be encouraged to provide the following clothes for their child:

- hat;
- coat for cold days — coats without draw strings are safer than those with draw strings;
- sun protective clothing for warmer days;
- a change of clothing — extra pants are necessary for children learning to use the toilet; and
- a second pair of shoes on wet days.

The centre needs to provide protective over-clothing for messy play activities.

Storage of clothing

All clothing needs to be labelled by the parent. The sharing of clothing should not be necessary and should be discouraged. Each child's clothing should be stored individually.

Clothing and safety

The developmental level of the child needs to be considered when dressing children. Guides for safety and comfort include:

- Dress babies, who are learning to crawl, in pants (dresses can become caught up).
- Dress children learning to use the toilet in clothes that they can easily and quickly manage.
- Fold back sleeve cuffs so they do not interfere with play or become wet during water play and hand-washing.
- Tuck dresses in during outside climbing activities.
- Watch for, and tie up, children's shoelaces when undone.

Rest/sleep requirements

Each child should have an identified sheet and blanket which is stored separately.

Over-heating can make children uncomfortable and can interrupt their sleep. Excess clothing such as jumpers,

braces, shoes and socks need to be removed as part of preparation for rest/sleep. They should be stored separately. For safety reasons, bibs must be removed. Encourage each child to help.

Children's preference for clothing

At different times children may be resistant to staff requests to put on or take off particular pieces of clothing. The timing may not be right for the child or they are comfortable as they are. Children are often more active than adults and thus warmer. Some children do not feel the heat or cold as much as others, so resistance should not be simply ignored. Talk with the child, explaining why it may be necessary to have extra or less clothing. Often, if a little time is given, the child will be ready to participate.

Possible policy and procedure issues

Some issues your centre may wish to consider are:

- storage of children's personal clothing and belongings;
- dress code for play;
- sleep/rest practices;
- respecting individual children's dress preference; and
- information for parents on clothing and bedding requirements.

Sun protection

Incidence of skin cancer

Australia has the highest incidence of skin cancer in the world. Research shows that skin damage and skin cancer are cumulative. Sunburn as a child and adolescent is when most of the damage is done. Generally, the younger the child when sunburnt, the greater the problem. One or two bad cases of sunburn as a child could be the cause of skin cancer 20–30 years later (NSW Cancer Council).

Protective clothing

Staff and parents need to be positive role models for the children. Hats, sun glasses, sun screen, and protective clothing should be worn when necessary.

Hats

The different cancer councils of Australia recommend a Legionnaire's cap or a wide-brim hat. An 8–10 cm brim is best and will give about 50 percent shade protection to the face, including the eyes.

Clothing style

Shirts should cover the shoulders and upper arms. Longer sleeves are preferred, and looser sleeves that allow some ventilation are cooler. Closely-woven fabrics provide better protection from ultraviolet transmission than more loosely woven fabrics (ACT Cancer Society, 1993).

Sun glasses

Centres may like to consider whether or not their clothing policy makes any recommendations about children wearing sun glasses. Sun glasses are recommended by cancer councils from as soon as a child will leave them on. The best style to choose is one that wraps around the face to prevent any ultraviolet rays entering from the top or side of the glasses.

Latest evidence indicates that children and young adults may be at risk of eye damage from the sun because the ability of the lens to protect the retina is not evident until around 30 years of age. The Cancer Councils around Australia all recommend Polaroid with the maximum protection of Australian Radiation Laboratory, Eye Protection Factor (EPF) 10 UV rating. They will give up to 99.9 percent glare elimination. If these are not available, glasses that at least comply with the Australian Standard AS 1067–1990 should be used.

(The Royal Australian College of Ophthalmologists Policy Statement, 1991).

Sunscreen

When outdoor activities are programmed for early in the morning, parents could be asked to apply sunscreen before leaving home for the child care centre. An SPF 15+ broad spectrum, water resistant sunscreen is best. Sunscreen needs to be applied onto clean, dry skin 15–30 minutes before going out into the sun. This allows time for the sunscreen to bond with the skin. Sunscreen needs to be applied to all areas exposed to the sun:

- face
- ears
- neck
- arms
- backs of hands
- legs and tops of feet, including the skin exposed through the tops of sandals.

Take care when applying sunscreen onto children's faces, especially around the eye area, as eye irritation may occur. Sunscreen on the backs of children's hands needs to be especially well rubbed in, as children may inadvertently rub it in their eyes.

Reapply the sunscreen every two hours, or more. Water, perspiration, and skin contact can decrease the amount of protection given. When the centre supplies sunscreen, care needs to be taken, as some people are sensitive to some sunscreens. Parent permission should be obtained.

Babies and sun

Children under the age of 12 months should not be put into direct sunlight. For this reason, sunscreen is not normally required. However, shade and protective clothing are necessary. When these are not available, sunscreen will be necessary.

When and how to avoid the sun

Consideration for shade needs to be given during the early planning stages of the outdoor area.

Confine outdoor activities to shaded areas for the hours before 11.00am and after 3.00pm during daylight saving time and 10.00am–2.00pm Eastern Standard Time. The need to stay out of the direct sun can be discussed with older children.

Possible policy and procedure issues

Some issues your centre may wish to consider are:

- who will supply sunscreen?;
- who is responsible for applying children's sunscreen?;
- parent permission for sunscreen application;
- how will programming complement the sun policy?;
- are sunglasses to be part of the policy?; and
- can children play outside without the policy's recommended sun protective clothing and sunscreen?

Infection control

Principle 39: Staff adhere to hygiene principles which reduce the spread of infectious disease.
Principle 40: Staffing encourage children to follow simple rules of hygiene.

How does infection spread?

Research shows that children in child care, especially toddlers, are likely to have a higher incidence of infections compared with children not in care. Groups of children together in confined spaces, characteristic developmental behaviours such as lack of bowel and bladder control , under-developed immune systems, and incomplete immunisation all contribute to the higher rate of infection (Ferson, 1994).

Infection can spread rapidly. An infection control policy that is fully practised and regularly updated will control and minimise the spread of infection, not only among children but also staff and parents.

Infection can spread in the following ways:

- airborne droplets of infected discharge from mouth, nose, throat and/ or lungs (e.g. when coughing and sneezing);
- skin-to-skin contact (e.g. touching , hands, hair, open sores);
- faecal oral transmission (e.g. when hands or objects contaminated with faeces are placed in a person's mouth); and
- blood and other body fluids (e.g. when blood enters another person's body via a cut or break in their skin).

It should be noted that semen and vaginal fluids are not produced in sufficient amounts before puberty to be an infection risk (Ficke, C. & Glasson, M., 1992).

Preventing infection

1. Hand-washing

Correct washing of hands is the single most effective way to prevent the spread of infection.

When to wash hands:

Hands should be washed correctly and frequently during the day. Particular times for staff would include:

- before and after preparing and handling food — this includes feeding children, formula or otherwise, and feeding self;
- after cleaning;
- after using a tissue and after coughing or sneezing;
- after assisting children with nose-wiping;
- before and after giving first aid;
- after contact with blood;
- after personal toileting;
- after toileting children, including nappy changing;
- on arrival at work; and
- before departure from the centre.

Recommended times for the children would include:

- before and after handling food, both in preparation and eating;
- after playing outside;
- after toileting, including nappy change. (Young children often put their hands on their nappy area to explore when the nappy is taken off so, washing will help prevent the spread of infection via the faecal oral route. Washing hands at this time can be the start to the learning of such preventative health practices);
- after contact with discharge following sneezing, coughing, and using a tissue;
- after contact with blood;
- on arrival at the centre;
- before departure from the centre; and
- before and after water play.

Washing children's hands on arrival and before departure does have definite advantages. However, centres need to consider what works best for them. Think about the children's arrival and departure time and see if handwashing by children fits in comfortably with your routine. Discuss it with parents.

Technique:

Important steps in correct hand-washing are:

- use warm *running* water and soap;
- rub vigorously between the fingers, under the finger nails, the front, back and sides of hands and the wrists;
- rinse well under running water keeping the finger tips pointing down;
- dry hands well with a piece of paper towelling; and
- turn the tap off with a single-use piece of paper towelling.

Liquid soap is more hygienic than a cake of soap.

2. Hand-washing facilities

The physical environment will influence the frequency of hand-washing. Ideally hand-washing facilities need to be available in the kitchen, next to the nappy change area, in the bathroom, in the play room and in the outdoor areas for staff.

Supervision requirements can stop outside staff from going inside to wash hands after wiping a child's nose, for example. An outside wash basin is most useful, but not all centres have such facilities included in their design. Awareness of the problem and ways to reduce the risk of infection still need to be considered. One method for consideration could be the use of wet wipes with a antibacterial solution added. At the first opportunity staff should wash their hands with warm water and soap.

Hand-washing facilities for the children need to be at their height. Have soap available and paper towelling.

Individual hand towels, if used, need to be easily identifiable by each child. They should be washed daily in hot water.

Liquid soap is preferred to a cake of soap. The pump top of the dispenser needs to be included in the daily bathroom cleaning routine, as hands are not clean when they come in contact with it.

In order to prevent scalds, the hot water temperature in areas where children will use it should be set at no more than 50°C.

Child care workers need to be aware of the role model they are providing for children. When assisting children, encourage them to prepare by pushing their sleeves well up over their wrists so as to enable correct hand-washing and to prevent the discomfort of wet sleeves.

3. Gloves

The skin is the body's natural barrier against infection and, as long as it remains intact, correct hand-washing at the appropriate times will prevent the spread of a high percentage of infection. However, it is often difficult to know if the skin is

broken. Breaks may be very small and invisible at times (e.g. mild cases of dermatitis).

Gloves are recommended for particular procedures such as handling body fluids — urine, faeces, blood, and vomit. Gloves protect skin that is broken. They do not, however, take away the need to wash hands. Hand-washing is still just as important and must be done .

Well-fitting gloves such as latex are more practical than loose fitting 'one size fits all' styles.

Care should be taken when removing gloves to ensure that the contaminated surface does not come in contact with skin. Gloves should be peeled off from the wrist and disposed of in a plastic-lined, covered bin.

4. Cleaning and disinfecting

Cleaning and disinfecting are different and should not be confused.

Cleaning gets rid of the dirt that can be seen. This is can be done with hot water and soap. Areas requiring regular daily cleaning include bench tops, table tops, toys, taps, and floors.

Disinfecting gets rid of the dirt (germs) that cannot be seen. Sodium hypochlorite and quaternary ammonium compounds are recommended for this process.

Sodium hypochlorite (bleach) is effective in destroying most bacteria, viruses, and fungi. In order for bleach to be most effective, it should be mixed fresh each day, as it loses its strength by evaporation when exposed to the air (Kendrick, A. S., Kaufmann, R. & Messenger, K. P., Eds, 1988). Dilution required is one part bleach to nine parts water. Bleach is corrosive and so should not be used for wiping on or soaking metal objects (Department of Human Services and Health, 1994).

It should be noted that sodium hypochlorite is inactivated when it comes in contact with protein. Faeces contains protein. Thus an object must be well cleaned before it is disinfected. Care needs to be taken with quats and hypochlorite solutions, as skin contact can cause reactions.

Quaternary ammonium compounds destroy most bacteria. Quaternary ammonium compounds should be used in the way recommended by the manufacturer.

Areas and equipment requiring at least daily disinfecting include nappy change mats; toys mouthed by children who are unwell; and surfaces contaminated with blood, vomit, mucous, urine, or faeces.

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Spray bottles are not recommended for disinfectant application, as they can cause a build-up of chemicals in the air which may be dangerous when inhaled (Harris, M., *et al.*, 1994).

Ideally, though not exactly environmentally sound, single-use cleaning materials should be used. Alternatively, a coloured coded system of cleaning cloths can be used.

Refer to *Health and Safety in Child Care Centres: Model Policy and Practices* and *Workcover child care information* for more information relating to cleaning procedures.

5. Nappy change and toileting practices

Nappy change should occur as soon as possible after the need arises, in order to meet the child's comfort needs and to reduce the spread of infection. Correct hygiene practices should always be maintained.

Gloves should be worn — see point 3 in this chapter.

Preparing for nappy change:

Staff should avoid having the child's wet/soiled nappy come in contact with their own clothing as they take the child to the nappy change area. The use of steps up to the change area for older children helps to reduce this contact when lifting the child.

All necessary equipment needs to be within easy reach for the child care worker but out of the child's reach. This includes nappy pins/clips. Pins/clips frequently come in contact with urine, so a mouth is not the ideal place to put them!

Disposal of nappy and nappy contents:

Variations will occur in relation to nappy disposal, depending on whether the centre supplies and washes the nappies, sends each child's nappy home, or uses a linen service. Whichever practice is followed, immediate and correct disposal of the nappy is essential:

- Put a centre's cloth nappy into appropriate bucket.
- Put a child's own rinsed cloth nappy and soiled pilchers in a plastic bag. Place this bag inside another plastic bag with clothes.
- Fold a disposable nappy inwards and reseal with tapes, then put into a plastic-lined bin.

(Harris, M., *et al.*, 1994.)

If used for cleaning the child's nappy area, soiled wipes and paper should be placed directly into a plastic-lined, covered bin. If colour coded cloths are used, they should be placed into the appropriate covered bucket.

Choice of nappy cover:

Nappy covers, or pilchers, should be changed with each nappy and placed directly into a lined bin with a secure fitting lid. Research has shown the wrap-around pilchers are more hygienic than the pull-up type; they avoid contact with the legs and feet as they are taken off. It is also more hygienic to have pants on over the pilchers, as it decreases the contact of possible contaminated covers and legs with floor surfaces and other people. Research has also shown that disposable nappies are more hygienic than cloth nappies, both in general use and during outbreaks of diarrhoea (Van, R., Wun, C.C., Morrow, L. & Pickering L., 1991) (NSW Department of Health, 1993a). The researchers acknowledge the environmental problem of solid waste disposal.

Cleaning:

Always clean and disinfect the nappy change area after use. A nappy change mat made of a non-porous material will prevent urine and faeces remaining on it after cleaning. Clean the area with hot soapy water and then dry it thoroughly. Disinfect at times when a 10-minute interval between nappy changes can occur and at the end of the day. In order to be effective surfaces should be left in contact with the disinfectant for 10 minutes before wiping or allowed to air dry (Harris,M., *et al.*, 1994).

Potties should be emptied and cleaned immediately after use. Children learning to use the toilet should know that the potty — if used — is kept in the toilet area and that it is not shared. Wash and clean with a disinfectant in a similar manner to that for the nappy change area. Potties should not be cleaned in a basin used for hand-washing. Gloves need to be used as urine and faeces are being handled.

Child involvement:

Encourage children who have learned to use the toilet to flush it after use. Toilet flush button areas should be included in the daily cleaning routine, as they are high in contaminants.

Hand-washing at nappy change/toileting time:

The child care worker should always wash her/his hands

- after changing a nappy;
- after helping a child in the toilet or with a potty;
- after emptying and cleaning a potty;
- after cleaning the nappy change area; and
- after cleaning toilets and flushing toilets; even if gloves are worn.

Children should wash their hands or have staff help them

- after a nappy change; and
- after using, or trying to use, the toilet or potty.

6. Personal belongings

Particular infections can spread via shared clothing and bed linen. Personal belongings such as haircombs and brushes, toothbrushes and hats can also be responsible for spreading infections such as head lice and cold sores. Each child needs to have her/his own labelled bed linen which is washed when soiled and at least weekly. Separate storage of each child's bed linen will reduce the spread of infection.

Haircombs and brushes, toothbrushes and hats also need to be individually labelled and stored separately.

It is best if children do not bring their own toys to the centre, both for hygiene purposes and risk of loss or damage to personal property.

7. Toys and play environments

Centre toys need to be cleaned with soap and hot water, daily. Soft toys can usually be machine-washed. Toys that are mouthed need to be cleaned and disinfected. Sunlight is an excellent way to dry toys, as it will also kill some germs. Ease of washing should be considered as one of the selection criteria for purchasing toys.

Toys can be divided into two collections so that, on any one day, one lot is being cleaned and dried while the other is out for the children to play with.

Water play toys and containers can be ideal places for the spread of infection because of the moist environment and because water play is an activity often shared by a number of children at the same time.

The container and toys should be cleaned, disinfected, and dried daily (Kendrick, A. *et al.*, 1988).

Dramatic play clothes can be another means of the spread of infection because they are often shared by a number of children during the day.

8. Tears, dribbles, nasal discharge, and tissues

Tissues should be used only once and then discarded. After use they should go immediately into a lined bin with a secure fitting lid. Hands need to be washed after

- a child has used a tissue
- a staff member has assisted a child with a tissue, or
- a staff member has used a tissue.

Encourage children as much as possible to use tissues themselves. Tissues should never be shared by children.

9. Space and ventilation

The spread of infection is increased when children are confined to small, crowded places. The indoor room temperature and the amount of ventilation are two factors that can contribute to the spread. Try to take children outside for play as often as the program permits, monitor room temperature, and ventilate rooms daily by opening windows if practicable. Refer to the National Association for the Education of Young Children publication *Healthy Young Children* for further information.

10. Food practices

Refer to the Australian Early Childhood Association publication *Thought for food.*

Involvement of the children in infection control

Hand-washing can be used as a time to talk with the children about the importance of such hygiene practices. It should be a fun experience for children.

The facilities should be in easy access for the children. A step-up box may be necessary for small children to enable them to reach the water comfortably so that it does not run down to their elbows! Soap and paper towelling that are out of reach will not be used, defeating the purpose of hand-washing.

Remind and encourage the children to wash their own hands and to put away their personal belongings after use. Ensure time is given for them to do this at their own pace.

Possible policy and procedure issues

Some issues your centre may wish to consider are:

- can disposable nappies be used, especially during outbreaks of diarrhoea?;
- what type of nappy cover is recommended?;
- when will gloves be worn?;
- what will be used to dry hands?;
- what type of soap will be used — liquid or cake?;
- what cleaning agents will be used, and when?;
- how will children's personal belongings be stored?;
- criteria for toy selection; and
- disposal of nappy contents.

Dental care

Principle 40:
Staffing encourage children to follow simple rules of hygiene.

Dental care

Dental care is an important preventative health practice that needs to be encouraged and performed daily with the children.

Each centre will need to decide its policy for dental care. Will tooth brushing be practised after lunch? Will mouth rinsing with water be practised? Will certain foods be used to clean the teeth at the end of a meal? Will there be mixed practices?

Brushing teeth:

Tooth cleaning/brushing is encouraged at least three times a day, preferably after meals, from when the first tooth erupts. For infants, rubbing of the gums and tooth/teeth with a gauze-like cloth is equally effective.

The advantages of children brushing their teeth are:

- it helps to develop the habit of brushing teeth;
- it helps maintain healthy gums, and healthy gums assist in maintaining healthy teeth;
- healthy teeth make eating comfortable;
- healthy primary teeth influence the spacing and placement of secondary teeth; and
- healthy teeth influence language development.

Equipment:

Each child will require his/her own labelled soft-bristle brush. When bristles become bent the brush should be replaced, as it no longer cleans effectively. This will usually be about every three months. The issue of toothpaste use, and whether fluoridated or unfluoridated toothpaste is used, will need to be discussed with parents.

Supervision:

A staff member will need to supervise: assisting with toothpaste application; brushing; storing brushes; and discouraging sharing. Children under the age of eight years require individual help with brushing, as the manual

dexterity to clean teeth correctly is usually not developed until around this age.

Fluoride:

If the water supply is not fluoridated, the use of fluoride supplements might also be an issue for consideration. Over-use of fluoridated toothpaste can result in "fluorosis." Ways of reducing the problem can include:

- restricting the use of toothpaste to children over the age of two years or until they can follow instructions to spit toothpaste out;
- staff encouraging children to spit out the toothpaste, not to eat or swallow it;
- using junior toothpaste; and
- using only a pea-size amount of toothpaste.

Storage of toothbrushes:

Ideally, each toothbrush should be stored with the bristles upright, exposed to the air and not touching another toothbrush.

Mouth rinsing:

A centre may choose to have the children rinse their mouths after a meal instead of brushing their teeth.

Using water to do this helps to reduce the acidity in the mouth to a neutral pH and to remove some of the remaining food particles on the teeth and gums.

Foods that clean the teeth:

The use of certain foods at the end of a meal can help to protect teeth from decay. Dairy products such as milk, cheese, and yoghurt increase the level of calcium in the saliva, thus protecting the teeth. High-fibre foods such as celery stimulate saliva production which assists the pH in plaque to return to normal. Apples are best not used as a means for cleaning, because of their natural sugar content. Care must be taken not to give the hard, high-fibre foods, such as celery and carrot, to the younger children because of the risk of choking (Australian Dairy Corporation, 1992).

Positive dental care practices:

Ensure that children who drink from a bottle finish their drink before going to bed. The prolonged contact of fluids such as cordials, juices, and to a lesser extent milk with the teeth will increase the risk of dental caries (decay). The top front teeth are usually the most affected, the bottom front teeth being protected during non-sucking times by saliva.

Avoid the use of cordial drinks as much as possible.

Dilute fruit juices with water for children up until about the age of three years.

Take care with sugars in the diet. It is better for sugary foods to be eaten at the same time with other foods than to snack on them afterwards over a prolonged period (Australian Nutrition Foundation Inc., & The Dental Health Foundation, 1993).

Possible policy and procedure issues

Some issues your centre may wish to consider are:

- What form of dental care will be encouraged and when?
- Will different/individual dental practices be encouraged and supported?
- How will dental equipment be stored?
- Are fluoride supplements necessary?
- Nutrition recommendations for dental care.

Immunisation

Principle 43
The centre maintains a record of children's immunisation.

Immunisation status:

The National Health and Medical Research Council of Australia (NHMRC) recommended in 1985 that it be mandatory for children entering child care to be up to date with their immunisations. This recommendation has been implemented by some, but as yet not all, States and Territories (Ferson, M., 1994).

The 1989–90 National Health Survey revealed that outbreaks of the vaccine-preventable diseases are occurring at unacceptably high levels in Australia. The eradication of a disease requires very high vaccine acceptance rates, in excess of 95 percent. Currently only 53 percent of Australian children aged 0 – 6 years are fully immunised. Nearly 20 percent are either totally unimmunised or their status unknown (Castles I., 1992).

Different States and Territories require documented evidence of a child's immunisation status to be obtained by the director as each child enrols in child care. This is in the form of an Immunisation Certificate, which is part of each child's personal health record, but is also obtainable from the family doctor and Baby Health Clinics.

Medical records and updating:

Up-to-date records of each child's immunisation status should be maintained by the director. A copy of the current NHMRC childhood vaccination schedule should be available for reference. Three files are useful to maintain. They are:

- names of children who are up to date
- names of children not up to date
- names of children not immunised at all.

Details need to be kept in each child's medical records and frequently updated, i.e. every six months (Department of Human Services and Health, 1994). Children behind with immunisations could have a monthly reminder. In the event of a outbreak of an immunisation-preventable disease occurring, the children without immunisation against it would need to be excluded.

Regular liaison with local public health authorities should include the updating of changes which are occasionally made to the immunisation schedule.

Reporting infectious diseases

The centre director is responsible for reporting incidences of confirmed cases of immunisation-preventable diseases to the appropriate public health authorities.

Reactions caused by immunisations

Reactions vary with the different injections. They do not always happen. However, staff should be informed when a child has had an immunisation. Reactions seen may include:

- Diptheria, Tetanus, Whooping Cough (Triple Antigen) — slight swelling at the injection site and mild to moderate fever within several hours after the injection, lasting 1–2 days. Severe reactions are very rare but can include persistent screaming, vomiting, collapse, or neurological complaints; and
- Measles, Mumps, Rubella (MMR) — slight swelling at the injection site; fever 5–14 days later; occasionally swelling of glands, headache, aching joints, malaise and/or rash. Neurological complications are rare (ACT Personal Health Record, 1991).

Staff immunisation

Staff records should contain up-to-date immunisation details on each staff member. Special attention should be given to ensuring new members are aware of the recommendations for staff.

The NHMRC recommends that child care workers have the following immunisations up to date:

- measles-mumps-rubella (MMR);
- oral polio (Sabin);
- diphtheria and tetanus (ADT); and
- hepatitis A, for those working with children under the age of two years (NSW Department of Health, 1993a).

The ADT (adult diphtheria and tetanus) should continue to be given once every 10 years (NHMRC, 1994). People often think that, if they receive a tetanus booster in the form of a tetanus toxoid vaccine, they are adequately covered. However, they are not, as they miss out on the diphtheria immunisation.

Continued pertussis immunisation for adults is not recommended (NHMRC, 1994). Adults, however, can be carriers of pertussis in a mild but contagious form. Care with personal hygiene when coughing and sneezing will help to reduce the spread of pertussis.

At present a vaccination against tuberculosis (TB) would be considered only if there were a proven outbreak at the centre. Preschool children are not considered to be contagious when they have TB, because they do not have a productive cough and carry only a very small load of TB bacteria in their lungs (NSW Department of Health, 1993a).

Cytomegalovirus (CMV) remains a concern for women of child-bearing age, especially if contracted for the first time during pregnancy, as it can cause damage to the unborn child. A vaccine is not available at present, however, an immunity level can be done before pregnancy. Particular care should be taken with hand-washing, as the virus is spread in body secretions which can

enter the body via mucous membrane and cuts in the skin (Department of Human Health and Services, 1994).

Staff may also wish to consider whether or not they are immunised against other infections such as hepatitis B.

Parent information

Statistics show that child immunisation levels fall dramatically in the first two years. Parents may need a reminder to keep immunisations up to date.

Displays of the current immunisation schedule and copies of it may help to do this.

A local paediatrician or community nurse could be invited to give regular updates, either at parent meetings or through the centre's newsletter.

Some States now have immunisation clinics open in the evening to help working parents who are unable to visit during the day.

Civil liberties

Some people may argue that the requirement to provide immunisation details represents an infringement of civil liberties. The NSW Health Department has been advised by the NSW Council of Civil Liberties that requiring documented evidence of immunisation status at enrolment is not an infringement of civil liberties (NSW Health Department, 1993b).

Possible policy and procedure issues

Some issues your centre may wish to consider are:

- a system to be used for recording and updating each child's immunisation status;
- staff development programs to update staff on current immunisation schedules and on possible reactions caused by immunisation;
- immunisation recommendations for staff;
- displays of current immunisation information; and
- availability of immunisation information for parents.

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